STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013613	A. BUILDING: _____ B. WING _____	R 06/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS DEMENTIA CARE INC	**4301 WASHINGTON AVE EVANSVILLE, IN 47714**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on May 2, 2016. Survey date: June 6, 2016 Facility number: 013613 Provider number: 013613 AIM number: N/A Census bed type: Residential: 19 Total: 19 Census payor type: Other: 19 Total: 19 Sample: 3 Oasis Dementia Care, Inc. was found to be in compliance with 410 AC 16.2-5 in regard to the PR to the State Residential Licensure Survey. Quality review completed by #02748 on June 7, 2016.	{R 000}		